Volume 18, Issue 1

January / February 2000

MESSENGER

The Michigan Conference of Teamsters Welfare Fund

BENEFIT IMPROVEMENTS REMAIN THE FUND'S TOP PRIORITY

TOTAL AND PERMANENT DISABILITY BENEFIT

The Trustees of the Michigan Conference of Teamsters Welfare Fund continuously strive to improve membership benefits. Recently the Fund revised the rules under the Total & Permanent Disability Benefit. The following shall apply to eligible Active Members who become totally disabled ***on or after February 1, 2000***.

Active Members covered by the Fund under a Benefit Plan that provides Total and Permanent Disability Benefits, who become totally and permanently disabled, as defined below, shall be eligible to receive the Total and Permanent Disability Benefit subject to the following criteria.

A Member is totally and permanently disabled if the Trustees determine, based on evidence satisfactory to them, that the Member has a physical or mental condition that is expected to continue for the remainder of the Member's life and that causes the Member to be unable to engage in any regular employment or occupation for remuneration or profit for which the Member may be suited by education, training or experience. In making this determination, the Trustees may consider, for example, whether the Member's physical or mental condition makes the Member unable to engage in employment that provides a similar level of income as the employment he or she was able to engage in without the physical or mental condition.

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The Trustees shall be the sole judge of whether a Member is totally and permanently disabled and whether the Member is entitled to a Total and Permanent Disability Benefit. The Trustees may consider as evidence, but are not bound by, a determination by the Social Security Administration concerning an applicant's total and permanent disability.

The Trustees may require an applicant for Total and Permanent Disability Benefits to submit to an examination by a physician or physicians selected by the Trustees and to provide evidence of earnings or compensation as the Trustees may direct. The Trustees may require an individual receiving a Total and Permanent Disability Benefit to submit to re-examination periodically (but not more often than annually) and to provide evidence of earnings or compensation as the Trustees may direct. An individual who fails

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or refuses to submit to an examination or provide earnings or compensation information requested by the Trustees will not be entitled to a Total and Permanent Disability Benefit.

Previous rules required that an Active Member who became totally and permanently disabled had to be continuously disabled for at least nine (9) consecutive months when the application was received by the Fund. **This waiting period has been eliminated.**

Also, previous rules required that the member had to receive a Social Security Disability Award in which the Social Security Administration determined eligibility for disability benefits within twelve (12) months after termination of his/her active coverage. As stated above, under the new Total and Permanent Disability rules, the Trustees *may consider as evidence, but are not bound by,* a determination by the Social Security Administration concerning an applicant's total and permanent disability.

If an active employee, covered by SOA, TIF, Key I or Key II Plans, has met the requirements for the Total and Permanent Disability Benefit, the Fund will pay a monthly benefit of $250. The first payment will commence on the first day of the month following the date that the payment of the benefit is approved, and will continue each month thereafter while the employee remains totally and permanently disabled, up to a maximum of 80 months.

If the employee dies while receiving Total and Permanent Disability Benefits, the spouse or designated beneficiary will receive the remaining benefits in a single lump sum payment.

Please remember, the Fund requires that you file an application for Total and Permanent Disability Benefits within twelve (12) months after the termination of active coverage. Applications received beyond the twelve (12) month period will be denied.

CONTINUATION OF POST RETIREE SUPPLEMENTAL PHARMACY PROGRAM

The Trustees of the Welfare Fund are pleased to announce that the Post Retiree Supplemental Pharmacy Program will be continued for the calendar year 2000 (1/1/2000 through 12/31/2000). The annual $1,000 maximum was re-established on January 1, 2000 for all participants of the program. Remember, even after a participant has met their maximum, monthly payments must continue to be submitted to the Fund through December, 2000, or you will not be eligible to continue in the program in the future.

In order to be eligible in this program you must file an Application form during the 61 day period beginning on the 30th day immediately preceding your retirement date and ending on the 30th day immediately following your retirement date.

All current participants who have submitted claims incurred between 4/1/99 and 10/1/99 (which was prior to receiving your card) to the Fund, should expect to receive reimbursement of eligible expenses shortly, if they have not already.

HUMAN ORGAN TRANSPLANT BENEFIT INCREASES

Effective January 1, 2000 the Human Organ Transplant maximum benefits significantly increased. These increases, which are shown in this chart, effect both the surgical costs as well as the follow up treatment for SOA, TIF, I&S, Key I, Key II and PEP active plans. (the transplant benefit is a named exclusion under the Retiree Plan). Annual follow-up maximums for all organs (except cornea) have been increased to $25,000 and the lifetime maximums to $100,000.

Expenses payable under the surgical benefits include hospital and related facility charges, physician fees, ancillary charges and all expenses associated with the surgical transplant procedure.

The annual follow up benefits are on a calendar year basis. The benefit includes professional fees, hospital and related facility charges, ancillary charges and expenses resulting directly from the transplant procedure after discharge from the hospital where the transplant occurred.

For the lifetime follow up benefit, if the actual surgical costs are less than the maximum surgical benefit, the unused surgical benefit may be added to lifetime benefit.

Donor expenses incurred in the transplant procedure will also be included in the limits listed.

REVISED MAXIMUM BENEFITS EFFECTIVE 1/1/2000

Organ	Surgical Benefits Prior To 1/1/2000	Surgical Benefits	Annual Follow-Up Benefits	Lifetime Follow-Up Benefits
Heart	$100,000	$175,000	$25,000	$100,000
Heart/Lung	$150,000	$200,000	$25,000	$100,000
Lung	$150,000	$200,000	$25,000	$100,000
Liver	$125,000	$150,000	$25,000	$100,000
Pancreas	$50,000	$100,000	$25,000	$100,000
Kidney	$50,000	$100,000	$25,000	$100,000
Cornea	$10,000	$10,000	N/A	N/A
Bone Marrow Autologous	$150,000	$150,000	$25,000	$100,000
Bone Marrow Allogeneic	$150,000	$200,000	$25,000	$100,000
Bone Marrow Allogeneic Unrelated	$150,000	$250,000	$25,000	$100,000

UPDATE ON LABORATORY BANKRUPTCY

The bankruptcy judge presiding over the Universal Standard Healthcare ("Universal") bankruptcy case has issued an Order forbidding providers from balance billing participants in the Michigan Conference of Teamsters Welfare Fund ("Fund") for dates of service prior to August 1, 1999 (the bankruptcy period).

Under the order, laboratory service providers are prohibited from balance billing Fund participants for services provided before August 1, 1999. In addition, "Electing Providers" (laboratory service providers who agree to accept the bankruptcy Trustee's settlement offer) will release the Fund and its participants from claim liability, will not bill for any claim, must cease all actions against participants to collect claims and must correct and clear related negative credit reports concerning participants.

To discourage further collection action against participants, we are sending a copy of the order to all laboratory service providers, sending a copy of the order to any laboratory service provider that bills a participant (with a warning that it is violating the order), and will provide a copy of the order upon request to participants who may need documentation to clear their credit reports.

As a reminder, the Fund will process lab claims for dates of service August 1, 1999 and forward.

If you have any questions or would like a copy of the order, please call our Member Services Department.

Fund Trustees Renew Eight-Week Benefit Banks for 2000-2003

The Trustees of the Michigan Conference of Teamsters Welfare Fund are pleased to announce that they have voted to once again renew the eight week Benefit Bank effective April 1, 2000.

The Benefit Bank is a "bank" of weeks that allow continued medical coverage for Teamster members participating in the SOA, TIF, UE, Key I and Key II medical plans during weeks that their employer is not required to make contributions on their behalf. The Benefit Bank weeks are available to members during illness, lay-off, job transfer, when involved in a sanctioned strike, or who are on a personal leave.

This new, three-year extension of the Benefit Bank represents the Trustees' commitment to the participants of the Michigan Conference of Teamsters Welfare Fund to avoid interruption in coverage.

Significant Benefit For Fund Members

The Trustees believe that the Benefit Bank is an important benefit for Teamster members since it relieves the financial burden of self payment of health care premiums if a member should go through a short-term layoff or be off the job for other reasons.

Members become eligible for the Benefit Bank renewal on April 1, 2000 if they are currently covered by one of the Plans mentioned above and are actively employed. If coverage begins after April 1, 2000, the member will be entitled to the Benefit Bank on the date their medical coverage begins

All eligible members start with eight weeks of extended coverage in his or her Benefit Bank, which can be used through April 1, 2003. Members who were in the process of using their Benefit Bank weeks at the March 31, 2000 expiration date may continue their use until depletion. These members' Bank Weeks will be renewed upon their return to active employment.

Benefit Bank weeks do not apply to members who terminate their employment voluntary or involuntary or if their employer discontinues participation in the Fund. However, *Members who are terminated due to testing positive for alcohol or drugs* shall be eligible for retroactive use of available benefit bank weeks upon meeting the following conditions:

- Completion of an approved course of evaluation/ rehabilitation by the fund's Behavioral Healthcare program.
- Documentation is submitted from the evaluation/ rehabilitation facility that the treatment has been satisfactorily completed and/or the member is capable of returning to work
- Return to active employment with employer contributions on his/her behalf
- Benefit bank weeks are available to post retroactively against the period, or a portion of the period, of evaluation/treatment.

Members having any questions concerning how the Benefit Bank program works or regarding their eligibility should call the Fund office at (313) 964-2400, ext. 430 or utilize the toll-free number for your area of the state.

Coverage For Dependent Children

Plan coverage is available for your "eligible dependent children" when your coverage begins, or if later, on the date they become your eligible dependent children. A dependent child of a covered member under a benefit plan offered by the Michigan Conference of Teamsters Welfare Fund means an individual who meets the below requirements.

A child of a Member by birth or legal adoption, or an individual claimed as a dependent of the Member on the Member's most recent federal income tax return who:

- Has not attained age 19
- Has not attained age 24 and is a full-time student (as demonstrated by a "Full-Time Student Eligibility Verification" form that must be submitted to the Fund for each school grading period); or
- Is determined by a licensed physician, psychologist or psychiatrist to be permanently and totally disabled by a disability that commended while the individual was covered as a dependent as defined in one of the above two rules) by a benefit plan offered by the Fund.

Remember, you must notify the Fund office in writing in the event of any change in your family status.

RECOVERY OF CLAIM OVERPAYMENTS

FUND POLICY REMINDER

In the event of an overpayment of benefits for services provided to a participant or beneficiary under the Fund, the Trustees have the right to recover the overpayment from the participant or beneficiary, or any provider to whom or on whose behalf the payments were made.

Keep in mind that before payment is sought from the participant, every reasonable effort is made to collect from any other parties that may be involved, i.e. any other insurance the member might have or the provider of the service.

According to Fund rules, overpayments may be recovered using any one or more of the following methods chosen by the Trustees in their sole discretion:

- Repayment in a lump sum
- Repayment in installments
- Offset in a lump sum against amounts due the participant, beneficiary or provider
- Offset in installments against amounts due the participant, beneficiary or provider
- Any other reasonable method chosen by the Trustees.

Any questions or concerns you may have on this policy should be addressed to the Member Services Department by calling (313) 964-2400 extension 430.

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The Michigan Conference of Teamsters Welfare Fund

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313-964-2400
Metro Detroit 1-800-572-7687
Upstate Members 1-800-824-3158
Out-of-State 1-800-334-9738

FUND TIP

Prior Authorization Requirements for Mental Health Services

Personal problems can affect your job, family, social life, as well as your emotional and physical well being. If you, or a family member are experiencing psychological or substance abuse problems, call the Teamsters Confidential Help Line for prior authorization and a referral for care.

All Active Members, regardless of Plan selection (A, B, or C) must call 1-800-457-8540 for inpatient and outpatient services.

All inpatient services for **Retired Members** need prior authorization, which the facility must obtain by calling (313) 964-2400, extension 428. Outpatient services for retired members do not require prior authorization.

Please note, failure to obtain prior authorization where required can result in the denial of payment of services.